MISSISSIPPI HEALTH BENEFITS

application

FOR MISSISSIPPI HEALTH BENEFITS

FOR FAMILIES AND CHILDREN

FOR OFFICE USE ONLY
Case Name
Case Number
County Number ☐ 85 ☐ 87 ☐ 88 ☐ 91 ☐ 99
Date Received

If you or your children have Medicaid, you do not need to fill out this form.

HELP

Please fill out this application honestly and completely. Please print.

1. HEAD OF HOUSEHOLD (Parent or Caregiver)

Last Name ..... First Name ..... MI .....

Are you pregnant? ☐ Yes, Due Date..... No ☒

If you are applying because you are pregnant, you need to give us a written statement from your doctor or health care provider saying you are pregnant and giving your expected date of delivery. Use the space on the back of this form or give us a separate statement.

Home Address ..... Apt. or Lot # .....

City ..... County ..... State MS Zip Code .....

Home Telephone No. ..... Work Telephone No. .....

Mailing Address (if different) .....

City ..... State MS Zip Code .....

2. HOUSEHOLD MEMBERS

(List everyone in your household, starting with yourself first.) Attach proof of age for your children you are applying for, such as a copy of birth certificate(s).

Are you person?		Full Name	Social Security Number (for all applying)	How is this person related to you?	Date of Birth	Sex	Race	US Citizen? (for all applying)		Pregnant?	
Yes	No							Yes	No	Yes	No
☐	☐			SELF		M		☐	☐	☐	☐
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You must give us the Social Security # for any person who wants to be eligible for health benefits. The State will use the SSN to verify information such as income and insurance coverage and to help maintain files regarding eligibility. The SSN may be used to match with records in other agencies, such as the Social Security Administration, Internal Revenue Service, and Employment Security. If you mark "No" to U.S. Citizen, alien status for those applying must be verified to determine qualified alien status.

3. INCOME INFORMATION

List all earnings from employment and money from self-employment that you, your spouse, and children in your household receive. ATTACH PROOF OF INCOME FOR ONE (1) FULL MONTH. Send us the most recent full month's earnings. Only income of the legal parent(s) living in the home counts toward the children applying.

Name of Employed Person	Name of Employer	Address of Employer	Phone # of Employer	Gross Amount (before deductions)	How Often (weekly, bi-weekly, monthly)	Beginning Date of
					Weekly	
					Weekly	
					Weekly	

Could you get health insurance for your children through any employer named above if you had the money to pay the premiums?
❑ Yes ❑ No Which employer? .....

List any alimony, child support, pension, Social Security, rental income, retirement, strike benefits, unemployment, veterans, workers compensation benefits that you, your spouse, and children in your household may receive. ATTACH PROOF OF INCOME.

Person Receiving Benefit	Type of Benefit	Amount Received	How Often?
	Select Source		Weekly
	Select Source		Weekly
	Select Source		Weekly

Do you pay someone to take care of your child/children or to take care of a dependent adult who lives with you while you work?
❑ Yes ❑ No If yes, fill out this section….

4. CHILD/ADULT CARE EXPENSES

Name of Child Care Provider or Day Care Center	Phone #	Child's Name (or Adult's)	Cost	Who pays for this
			$ per Other	
			$ per Other	

If any children (under 18) that you are applying for have a parent who does not live in the household or who is deceased, fill out this section….

5. INFORMATION ABOUT AN ABSENT OR DECEASED PARENT OF CHILD

Child's Name	Absent or Deceased Parent's Name	Parent's Social Security # (if known)	Absent Parent's Employer	Last Known Address	Race	Sex	Date of Death

Has child support been ordered by the court? ❑ Yes ❑ No (If yes, tell us the place and date of the court order.)

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Has anyone applying for health benefits had any health insurance coverage in the past 6 months?
☐ Yes ☐ No If the answer is yes, complete the following….

6. HEALTH INSURANCE INFORMATION

Insurance Company or Employer Plan	Policy #	Name of Insured	Policy Holder's Name & Social Security #	End Date of Coverage

7. Do you want to apply for health benefits for up to 3 months prior to the date of this application, if it is available?*
☐ Yes If yes, which months? .....
(Attach proof of income for the month(s) that you need coverage, if different from what you told us in #3.)
☐ No

*CHIP will not cover prior months.

8. Please tell us where you got this application .....

9. RIGHTS AND RESPONSIBILITIES (Please read carefully.)

PRINT THIS FORM

- Children under 21 who are eligible for health benefits under Medicaid are eligible for free health check ups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT). For more information, contact your local Health Department or call 1-800-421-2408 and ask for EPSDT information.
- Adults and children eligible for Medicaid must select a HealthMACS primary care provider or one will be chosen for you from a list of participating doctors and clinics. Contact the Managed Care hotline at 1-800-627-8488 for more information.
- Information about Family Planning Services and WIC food services is available from your local Health Department.
- Information that you give is confidential. Your medical information can only be released if needed to administer the Medicaid or CHIP Programs. If you receive care or treatment under Medicaid or CHIP, you authorize the health care provider to release to Medicaid, DHS, and the CHIP insurer your medical records and information relating to your diagnosis, examination, and treatment.
- Information that you give may be reviewed and verified by state and federal staff. You must fully cooperate with state and federal workers if your case is reviewed. No additional permission is needed to get verification or other information.
- Your application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief.
- You may ask for a hearing if you are not satisfied with any action taken by the State of Mississippi in connection with your application for health benefits.
- Medicaid does not pay medical expenses that a third party, such as private health insurance, should pay. By accepting Medicaid, you agree to give your rights to any third party payment to the Division of Medicaid. These payments include payments from hospitals and health insurance policies.
- You are encouraged to cooperate in identifying and locating any absent parent or help in establishing paternity for the children applying unless you have good cause for not cooperating.

10. Please sign this statement:

I certify that the information I have provided above is true to the best of my knowledge, and I give permission for the State of Mississippi to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities that is printed above. I know that I could be penalized if I knowingly give false information. I certify that the children and adults I am applying for are U.S. citizens or qualified aliens.

Signature of applicant..... Date.....

MAIL THIS APPLICATION TO THE COUNTY DEPARTMENT OF HUMAN SERVICES OFFICE IN THE COUNTY WHERE YOU LIVE. If you need help with this application, call your county DHS office or call 1-877-543-7669.

Pregnancy Verification

Patient's Name ..... Pregnant ☐ Yes ☐ No

Expected Date of Delivery .....

First Maternity Visit .....

....

Signature of Medical Practitioner (MD/RN) Dat

Fold here and seal with tape. DO NOT STAPLE.

Fold here

To: .....

Street Address .....

City State Zip .....

From: .....

.....

.....

Tape closed

First Class
Postage Required

Post Office
Will Not Deliver
Without Proper
Postage